

Wisconsin Department of Regulation & Licensing

Mail To: P.O. Box 8935
Madison, WI 53708-8935

FAX #: (608) 261-7083
Phone #: (608) 266-2112

1400 E. Washington Avenue
Madison, WI 53703

E-Mail: web@drl.state.wi.us
Website: <http://www.drl.state.wi.us>

PHARMACY EXAMINING BOARD

PHARMACY CLOSING AFFIDAVIT

Information requested is required for processing.

☐ CHANGE OF OWNERSHIP
☐ REMODEL

☐ OUT OF BUSINESS

☐ CHANGE OF LOCATION

Closing Date: _____

Please TYPE or PRINT in INK

I hereby certify the below named pharmacy closed on _____ and the following action was taken:
(date)

PHARMACY: _____

ADDRESS: _____
number, street

city, state, zip code

ALL NON-CONTROLLED PRESCRIPTION DRUGS REMOVED FROM PREMISES AND RECEIVED BY:

NAME: _____

ADDRESS: _____

LICENSE #: _____

LICENSE #: _____

Managing R.Ph. _____

License #: _____

TRANSFERRED PRESCRIPTION FILES TO:

NAME: _____

ADDRESS: _____

LICENSE #: _____

ALL CONTROLLED DRUGS SUBJECT TO FEDERAL CONTROLLED SUBSTANCES ACT DISPOSED OF IN ACCORDANCE WITH 21 CFR 1307.21.

Transferred to:

Name: _____

Address: _____

Date of Final Inventory _____

Date of Transfer _____

FED. CSA REG. NO. _____

DEA Form #222 _____ YES _____ NO

1. Removed all drug signs and all symbols, insignia, etc., indicating the presence of a pharmacy. (For out of business pharmacies only. Not required for remodel requests.)

_____ YES _____ NO _____ N/A If yes, date: _____

State of Wisconsin Department of Regulation & Licensing

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2. Informed the telephone company in writing to remove all listings from the classified telephone directory. A copy of the letter is attached. (For out of business pharmacies only. Not required for remodel requests.)

_____ YES _____ NO

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3. Discontinued use of checks, stationery, wrapping paper, bags, etc., containing the words drugs, pharmacy, etc., or symbols indicating the operation of a pharmacy or the sale of drugs. (For out of business pharmacies only. Not required for remodel requests.)

_____ YES _____ NO _____ NIA If yes, date: _____

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4. Current pharmacy renewal license is enclosed. (For out of business pharmacies only. Not required for remodel requests.)

_____ YES _____ NO

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5. Forward a copy of this affidavit, DEA Certificate of Registration, and any unused DEA Form 222 Order Forms to: DEA, Attn: Registration, 230 S. Dearborn St., # 1200, Chicago, IL 60604. (For out of business pharmacies only. Not required for remodel requests.)
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AFFIDAVIT OF MANAGING PHARMACIST

The undersigned, having been duly sworn on oath, states that the facts and statements herein contained are true and correct based upon personal knowledge of the undersigned.

Managing Pharmacist Signature

Date

State of _____

County of _____

Subscribed and sworn before me this _____ day of _____, 20_____

by _____

SEAL

Notary Public, State of _____

My commission expires: _____

NOTE: This affidavit must be signed by the Managing Pharmacist in the presence of the notary public on the same date.